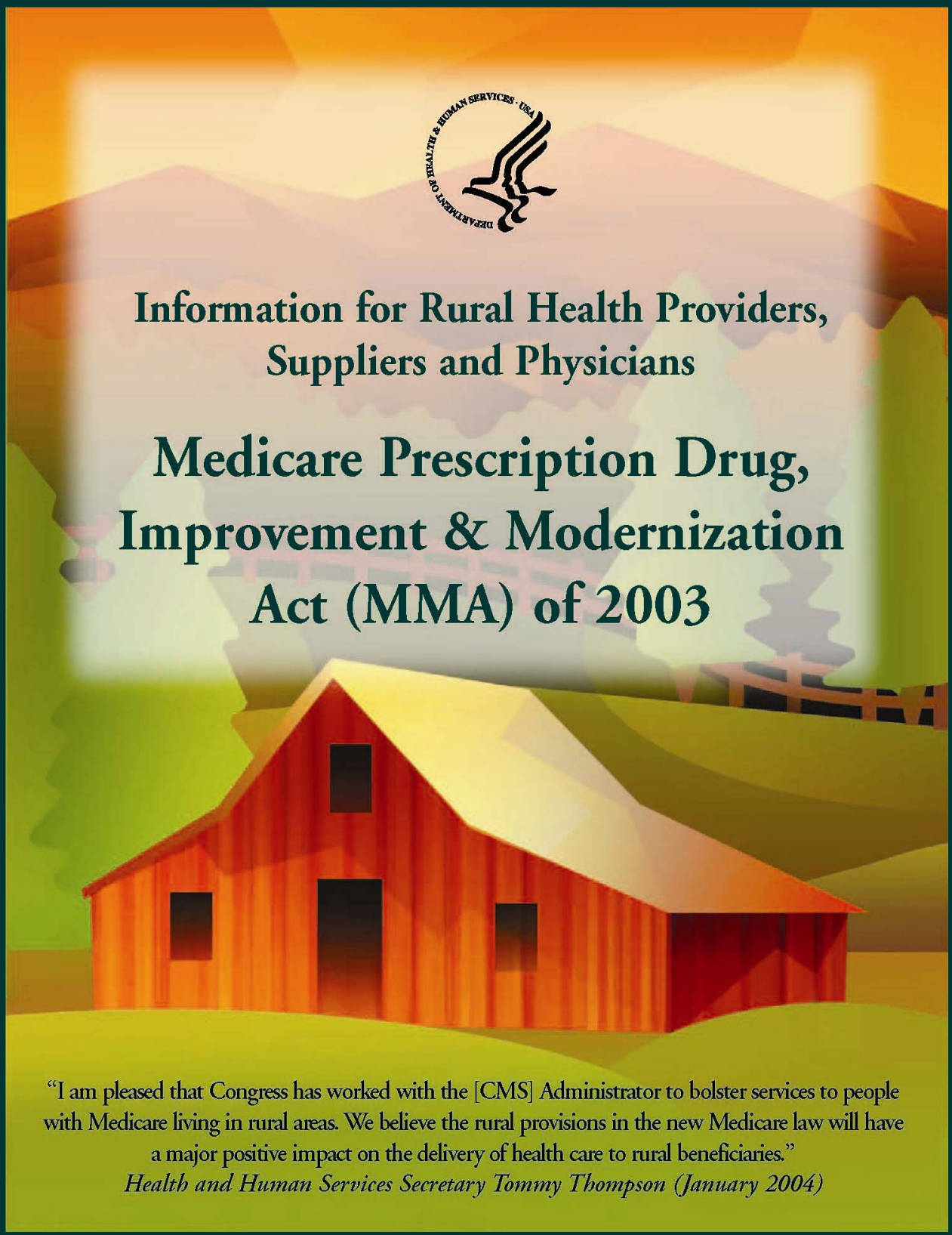

Information for Rural Health Providers, Suppliers and Physicians

Medicare Prescription Drug, Improvement & Modernization Act (MMA) of 2003

"I am pleased that Congress has worked with the [CMS] Administrator to bolster services to people with Medicare living in rural areas. We believe the rural provisions in the new Medicare law will have a major positive impact on the delivery of health care to rural beneficiaries."
Health and Human Services Secretary Tommy Thompson (January 2004)

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Learning Network

The Centers for Medicare & Medicaid Services (CMS) is committed to ensuring that Medicare beneficiaries who live in rural areas and underserved communities have access to the health care services that they need and deserve. The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 includes many provisions that strengthen the health care delivery systems that rural health providers, suppliers, and physicians depend upon. Some of the MMA provisions that are of particular interest to the rural health community are:

Hospital Inpatient Prospective Payment System

§401 – As of April 1, 2004, the urban and rural standardized amounts under the Hospital Inpatient Prospective Payment System (PPS) will be permanently equalized by establishing a single base payment, or standardized amount, for hospitals in all areas of the 50 States, the District of Columbia, and Puerto Rico. CMS has done the following:

- Equalized the standard amounts from April 1, 2003 to March 31, 2004;
- Increased the large urban and other area national adjusted amounts for Puerto Rico retroactive to October 1, 2003; and
- Equalized the Puerto Rico-specific urban and other area rates.

Although these changes were not be effective in Medicare systems until April 1, 2004, CMS has calculated the payment necessary to make up for the six months that Puerto Rico and other areas did not receive payments equal to Puerto Rico urban rates.

§401(d)(2) – From April 1, 2004 through September 30, 2004, the Puerto Rico-specific other area rates will exceed the Puerto Rico urban rate so that the requirements of the provision can be implemented without reprocessing claims.

§402 – For discharges on or after April 1, 2004, the Disproportionate Share Hospital (DSH) adjustment for rural hospitals (including Rural Referral Centers [RRC] and Sole Community Hospitals [SCH]) and urban hospitals with fewer than 100 beds will be increased. The cap on the adjustment will be 12 percent, except for hospitals classified as RRCs. The formulas to establish a hospital's DSH payment adjustment are based on the following:

- Hospital's location;
- Number of beds; and
- Status as a rural referral center or rural SCH.

Under §1886(d)(5)(F) of the Social Security Act, Medicare makes additional DSH payments to acute hospitals that serve a large number of low-income Medicare and Medicaid patients as part of its Inpatient PPS. The new DSH adjustment is not applicable to Pickle Hospitals, as defined at §1886(d)(5)(F)(i)(II) of the Social Security Act. Effective April 1, 2001, as specified in §211 of the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000, all inpatient PPS hospitals are eligible to receive DSH payments when their DSH patient percentage meets or exceeds 15 percent.

Hospital Inpatient Prospective Payment System Wage Index

§403(b) – For discharges on or after October 1, 2004, the percentage of hospital inpatient payment adjustment based on the area hospital wage index will be decreased from 71.1 percent to 62 percent. These payments are adjusted by the hospital wage

index of the area where the hospital is located or the area in which the hospital is classified. The decrease in the percentage of Hospital Inpatient PPS payment adjustment is applicable only if the hospital would receive higher total payments.

Critical Access Hospitals

§405(a) – Critical Access Hospitals (CAH) will be paid under the Standard Method Payment – Cost-Based Facility Services with Billing of Carrier for Professional Services, unless they elect to be paid under the Optional (Elective) Payment Method. For cost reporting periods beginning on or after January 1, 2004, outpatient CAH services payments have been increased to the lesser of the following:

- 80 percent of the 101 percent of reasonable costs for CAH services, which is up from 100 percent of reasonable costs for CAH services; **OR**
- 101 percent of the reasonable cost of the CAH in furnishing CAH services less the applicable Part B deductible and coinsurance amounts.

As of January 1, 2004, the Optional Payment Method – Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for Professional Services for outpatient CAH services is based on the sum of the following:

- The lesser of 80 percent of 101 percent of the reasonable cost of the CAH in furnishing CAH services **OR** 101 percent of the outpatient services less applicable Part B deductible and coinsurance amounts; **AND**
- 115 percent of the allowable amount, after applicable deductions, under the Medicare Physician Fee Schedule (MPFS) for physician professional services. Payment for non-physician practitioner professional services is 115 percent of 85 percent of the allowable amount under the MPFS.

For cost-reporting periods beginning on or after January 1, 2004, reimbursement for services furnished will be based on 101 percent of the CAH's reasonable costs, up from 100 percent of reasonable costs.

§405(b) – For services furnished on or after January 1, 2005, cost-based reimbursement will be extended to on-call emergency room physician assistants, nurse practitioners, and clinical nurse specialists who are on-call emergency room providers.

§405(c) – For services furnished on or after July 1, 2004, periodic interim payments will be paid every two weeks to CAHs that provide inpatient services and meet certain requirements.

§405(d) – For cost reporting periods beginning on and after July 1, 2004, each physician or other practitioner providing professional services in the hospital are not required to reassign their Part B benefits to the CAH in order for the CAH to select the Optional Payment Method. The following applies:

- For CAHs that elected the Optional Payment Method before November 1, 2003 for a cost reporting period that began on or after July 1, 2001, the effective date of this rule is retroactive to July 1, 2001; and
- For CAHs that elected the Optional Payment Method on or after November 1, 2003, the rule will be effective for cost reporting periods beginning on or after July 1, 2004.

§405(e) – Beginning on January 1, 2004, CAHs may operate up to 25 beds for acute, (hospital-level) inpatient care, subject to the 96-hour average length of stay for acute care patients. For CAHs with swing bed agreements, any of its beds may be used to furnish either inpatient acute care or swing bed services. Prior to January 1, 2004, CAHs could not operate more than 15 acute care beds or more than 25 beds if it included up to 10 swing beds.

§405(f) – The Medicare Rural Hospital Flexibility Program (FLEX) was reauthorized to make grants to all states in the amount of $35 million in each of Fiscal Years 2005 through 2008. The FLEX program makes grants for specified purposes to states and eligible small rural hospitals.

§405(g) – For cost reporting periods beginning on or after October 1, 2004, CAHs may establish psychiatric units and rehabilitation units that are distinct parts (DP) of the hospital. The total number of beds in each CAH DP may not exceed ten. These beds will not count against the CAH inpatient bed limit. The psychiatric and rehabilitation DPs must meet the applicable requirements for such beds in short-term general hospitals, and Medicare payments will equal payments to short-term general hospitals for these services.

§405(h) – Through January 1, 2006, states can continue to certify facilities as necessary providers in order for them to be designated as CAHs.

Low Volume Hospitals

§406 – Effective October 1, 2004, low volume hospitals can receive an additional percentage increase, capped at 25 percent, based on the relationship between the cost-per-case and the number of discharges for acute inpatient hospitals. A low volume hospital is a hospital that has less than 800 discharges during the fiscal year and is located more than 25 road miles from another acute care hospital.

Rural Health Clinics and Federally Qualified Health Centers

§410 – For services furnished on or after January 1, 2005, professional services provided by physicians, physician assistants, nurse practitioners, and clinical psychologists who are affiliated with Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) are excluded from the Skilled Nursing Facility PPS, in the same manner as such services would be excluded if provided by individuals not affiliated with RHCs and FQHCs.

Medicare Incentive Payment Programs for Physician Scarcity

§413 – For services furnished on or after January 1, 2005 and before January 1, 2008, a new Physician Scarcity Incentive Payment of five percent will be available to primary and specialty physicians in areas that have few physicians available. Counties must be identified based separately on the ratio of primary care physicians to Medicare eligible individuals residing in the county and on the ratio of specialist care physicians to Medicare eligible individuals residing in the county. To the extent that it is feasible, a rural census tract of a metropolitan statistical area, commonly known as the Goldsmith Modification area, will be counted as a scarcity area.

Effective January 1, 2005, the Health Professional Shortage Area (HPSA) Incentive Payment will be paid automatically for services furnished in full county primary care geographic area HPSAs rather than having the physician identify that the services are furnished in such area.

Ambulance Services

§414 – Effective July 1, 2004, an alternate fee schedule phase-in formula was established for certain providers and suppliers based on a specified blend of the national fee schedule and a regional fee schedule. If the alternate phase-in formula for a region results in higher payment, all providers and suppliers in that region will be paid under that formula and their phase-in would last through 2010. Mileage payment increases are as follows:

- Through 2008, mileage payments for ground ambulance trips that are longer than 50 miles will be increased by one-quarter of the payment per mile otherwise applicable to the trip.
- Through 2009, the base payment rate for ambulance trips that originate in rural areas with a population density in the lowest quartile of all rural county populations will be increased. The percentage increase will be based on the estimated average cost per trip, not including mileage, in the lowest quartile as compared to the average cost in the highest quartile of all rural county populations.
- Through 2006, payments will be increased by two percent for rural ground ambulance services and by one percent for non-rural ground ambulance services.

§415 – Effective January 1, 2005, rural air ambulance services will be reimbursed at the air ambulance rate if the services:

- Are reasonable and necessary based on the patient's condition at or immediately prior to transport; and
- Meet equipment and crew requirements.

Rural air ambulance services are deemed medically necessary when they are requested by:

- A physician or other qualified person who reasonably determines that land transport would threaten the patient's survival or health; or
- Recognized state or regional Emergency Medical Services personnel.

In most cases, the presumption of medical necessity does not apply if:

- There is a financial or employment relationship between the person requesting the air ambulance or his/her immediate family and the entity furnishing the service; or
- The entity requesting the service owns the entity furnishing the service.

Telemedicine Demonstration

§417 – Extends the telemedicine demonstration four additional years and authorizes an additional $30 million in funding. This demonstration uses high-capacity computer systems and medical informatics to improve primary care and prevent health complications in Medicare eligible individuals with diabetes mellitus who live in isolated rural and inner city areas.

Frontier Extended Stay Clinics Demonstration Project

§434 – A demonstration project will be conducted for three years under which Frontier Extended Stay Clinics located in isolated rural areas are treated as Medicare providers. The clinics must be located at least 75 miles from the nearest acute care hospital or be inaccessible by public road. The clinics must also be designed to address the needs of seriously ill, critically ill, or injured patients who, due to adverse weather conditions or for other reasons, need monitoring and observation for a limited period of time.

Graduate Medical Education

§712 – For cost reporting periods beginning on or after October 1, 2003, regardless of the reduction in the initial period of board eligibility by relevant medical boards, the geriatric exception to allow up to two years of additional training in a geriatrics program will be considered part of the initial residency period.

§713 – For a one year period, beginning on January 1, 2004, hospitals were allowed to count residents who were training at non-hospital sites in osteopathic and allopathic family programs that have been in existence as of January 1, 2002, regardless of the financial arrangement between the hospital and the supervisory teaching physician.

Rural Health Provisions Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003	
MMA SECTION	**PROVISION**
§401, §401(d)(2), §402, §504	Hospital Inpatient Prospective Payment System
§403(b)	Hospital Inpatient Prospective Payment System Wage Index
§404	Hospital Market Basket Weight Updates
§405(a) – §405(h)	Critical Access Hospitals
§406	Low Volume Hospitals
§407	Sole Community Hospitals
§408 - §409	Hospice
§410	Federally Qualified Health Centers
§410	Rural Health Clinics
§410(A)	Rural Community Hospitals
§411	Hold Harmless Reimbursement Provisions
§412	Work Geographic Adjustment
§413	Medicare Incentive Payment Programs for Physician Scarcity
§414 – §415	Ambulance Services
§416	Outpatient Hospital Clinical Diagnostic Laboratory Tests
§417	Telemedicine Demonstration
§418	Originating Telehealth Sites
§421, §701(a) – (b)	Home Health Agencies
§422	Unused Resident Positions
§432	Expanded Responsibilities of Office of Rural Health Policy
§433	Medicare Payment Advisory Commission Study
§434(a)	Frontier Extended Stay Clinics Demonstration Project
§502	Indirect Medical Education Adjustment
§711 - 713	Graduate Medical Education

Helpful Rural Health Websites

Centers for Medicare & Medicaid Services' Websites

CMS Contact Information Directory
www.cms.hhs.gov/apps/contacts

CMS Forms
www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage

CMS Mailing Lists
www.cms.hhs.gov/apps/mailinglists

Critical Access Hospital Provider Center
www.cms.hhs.gov/center/cah.asp

Federally Qualified Health Centers Provider Center
www.cms.hhs.gov/center/fqhc.asp

HPSA/PSA (Physician Bonuses)
www.cms.hhs.gov/HPSAPSAPhysicianBonuses

Hospital Provider Center
www.cms.hhs.gov/center/hospital.asp

Internet-Only Manuals
www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage

MLN Matters Articles
www.cms.hhs.gov/MLNMattersArticles

Medicare Learning Network
www.cms.hhs.gov/MLNGenInfo

Medicare Modernization Update
www.cms.hhs.gov/MMAUpdate

Physician's Resource Partner Center
www.cms.hhs.gov/center/physician.asp

Regulations & Guidance
www.cms.hhs.gov/home/regsguidance.asp

Rural Health Clinic Provider Center
www.cms.hhs.gov/center/rural.asp

Other Organizations' Websites

Administration on Aging
www.aoa.gov

American Hospital Association Section for Small or Rural Hospitals
www.aha.org/aha/key_issues/rural/index.html

Health Resources and Services Administration
www.hrsa.gov

National Association of Community Health Centers
www.nachc.org

National Association of Rural Health Clinics
www.narhc.org

National Rural Health Association
www.nrharural.org

Rural Assistance Center
www.raconline.org

This booklet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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Revised April 2006
ICN: 006422